No. 96-110

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., PH.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE CALIFORNIA MEDICAL ASSOCIATION, AND THE SOCIETY OF CRITICAL CARE MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE*

Pursuant to Rule 37.2 of the Rules of this Court, the American Medical Association ("AMA"), the California Medical Association ("CMA"), and the Society of Critical Care Medicine ("SCCM") respectfully move for leave to file the attached brief as *amici curiae* in support of the petition for a writ of certiorari submitted by the State of Washington. The respondents, Drs. Harold Glucksberg, Abigail Halperin, Thomas Preston, and Peter Shalit, have refused to consent to the filing of this brief.

The AMA is a private, voluntary, non-profit organization of physicians. It was founded in 1846 to promote the science and art of medicine and to improve the public

health. Its 290,000 members practice in all states and in all fields of medical specialization.

The CMA is a statewide professional organization dedicated to the health of Californians. With 34,000 members, it is the largest state medical association in the country.

The SCCM is the premier professional international organization devoted exclusively to the advancement of multidisciplinary critical care through excellence in patient care, education, research and advocacy. The nearly 9,000 members of SCCM—the intensivists, nurses and allied health professionals involved in the care of the critically ill and injured—blend their knowledge, skill, and expertise into a coordinated effort to achieve the best possible outcome for the patient.

Many of *amici*'s members are deeply interested in, and may be directly affected by, the Ninth Circuit's holding that laws prohibiting physician-assisted suicide are unconstitutional. The decision directly affects not only the Washington statute that was held invalid as applied in this case, but also the similarly worded California, Alaska, Arizona, and Montana statutes,* as well as the common law in the remaining four states of that circuit. Moreover, the statutory prohibitions in these states apparently are comparable to those in force in at least 27 other states (see Pet. App. at A-135 to A-136 n.10) (Beezer, J., dissenting) (citing state statutes).

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* *See* Wash. Rev. Code § 9A.36.060 (felony if a person "knowingly causes or aids another person to attempt suicide"); Alaska Stat. § 11.41.120 (felony if a person "intentionally aids another person to commit suicide"); Ariz. Stat. § 13-1103 (felony for "intentionally aiding another to commit suicide"); Cal. Penal Code § 401 (felony if a person "deliberately aids, or advises, or encourages another to commit suicide"); Mont. Stat. § 45-5-105 (felony if a person "purposely aids or solicits another to commit suicide").

The interest of *amici* in the Ninth Circuit's holding emerges from their role not only in representing American medical professionals but also in developing standards for defining the ethical practice of medicine. For example, at the first official meeting of the AMA in 1847, one of the two principal items of business was the establishment of a code of professional ethics. Since then, generations of physicians have volunteered countless hours to maintain, revisit, and, where appropriate, revise that code. Such efforts resulted, for example, in the 1989 decision of the AMA's Council on Ethical and Judicial Affairs ("Council") to affirm that it was not unethical for physicians to honor the wishes of patients that life-prolonging medical treatment be withheld or withdrawn. See AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* ("*Code of Medical Ethics*") § 2.20 (App. 12a-13a).

In the same tradition, the Council in 1991 began a detailed reassessment of the longstanding ethical prohibition of physician-assisted suicide. The Council's conclusions were set forth in two reports, *Decisions Near the End of Life*, 267 J.A.M.A. 2229 (1992), and *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues in L. & Med. 91 (1994) (App. 2a-11a). This work, in turn, formed the basis for the Council's decision in 1994 to adopt Opinion 2.211, which confirms and clarifies the AMA's position that physicians should not assist patients in committing suicide. *Code of Medical Ethics* § 2.211 (App. 1a). On June 25, 1996, the AMA's House of Delegates voted to affirm that position by a wide margin. *AMA Delegates Vote Overwhelmingly to Oppose Physician-Assisted Suicide*, 5 Health L. Rep. (BNA) 1033 (July 4, 1996).

The CMA, similarly, has vigorously opposed the legalization of physician-assisted suicide, which is prohibited by California law. Notably, CMA's Board of Trustees voted in 1992 to oppose California's "Physician-Assisted Death" initiative (Proposition 161) and, since then, has

consistently affirmed that position. Because California's law prohibiting physician-assisted suicide is threatened directly by the Ninth Circuit's holding, CMA members have an especially significant interest in the disposition of this case.

SCCM's involvement in ethical issues is a long-standing priority of the organization. Position papers and articles on patient triage, appropriateness of life-sustaining treatment and other ethical issues—developed by the SCCM Ethics Committee—have been published in SCCM's peer-reviewed journal, *Critical Care Medicine*, and other prestigious journals. SCCM's initiative to address care at the end of life includes contacting critical care professionals (SCCM members and others) at hospitals and medical centers nationwide to encourage frank discussion about end of life care; expediting the adoption of the multidisciplinary team model of critical care; ensuring that hospital ethics committees are accessible to patients, families, and health care practitioners; and convening "Critical Caring: A Consensus Conference on Care at the End of Life" in Washington, D.C.

The AMA, CMA, and SCCM seek to participate as *amici* in order to ensure that our nation's laws are informed by reasoned and time-tested ethical standards. The AMA has expressed its position before this Court on issues of similar concern, see, *e.g.*, Brief of the AMA *et al.* as *Amici Curiae* in Support of Petitioners, *Cruzan* v. *Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (No. 88-1503), and it submitted an *amicus* brief below in support of the State of Washington's position in this case, Brief of the AMA as *Amicus Curiae*, *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 94-35534). The Ninth Circuit, moreover, devoted a significant portion of the decision below to responding to the AMA's position, Pet. App. A-80 to A-81, A-90 to A-96, and to evaluating, more generally, the potential impact of its holding on the medical profession, Pet. App. A-77 to A-81. For all of these reasons, the AMA, CMA, and SCCM seek the opportunity to present their views as to why this case merits this Court's review. Accordingly, *amici* urge the Court to grant leave to file the *amici curiae* brief that accompanies this motion.

Respectfully submitted,

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QUESTION PRESENTED

Amici Curiae will address the following question:

Whether a terminally ill, competent individual has a constitutionally protected right to obtain the assistance of a physician in order to commit suicide.

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE CALIFORNIA MEDICAL ASSOCIATION, AND THE SOCIETY OF CRITICAL CARE MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

Descriptions of *amici* and their long and continued involvement in considering and setting ethical standards for the medical profession, and in participating in and stimulating debate both within and outside the medical profession on the difficult issues of caring for patients with serious illness and depression, are set forth in the accompanying motion for leave to file this brief. That motion also sets forth a number of reasons why this case is of particular interest to *amici*, including *amici*'s desire to

respond to the Ninth Circuit's extended discussion of the AMA's submission below regarding the impact of this decision upon the medical profession, the AMA's participation before this Court in its consideration of *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), the CMA's direct interest in the fate of California's statutory prohibition of physician-assisted suicide, and the SCCM's longstanding efforts to address and educate physicians and patients regarding medical care at the end of life. Most fundamentally, *amici* are interested in this case because of the profound and harmful impact that the Ninth Circuit's decision will have on the trust between physician and patient that is crucial to the physician-patient relationship and to the integrity of the medical profession.

Amici recognize the imperative of developing adequate medical and social responses to the needs of patients at the end of life. As discussed below, however, they believe that physician-assisted suicide is incompatible not only with the ethical traditions of medical practice but with the long-term interests of patients and physicians. In reaching that conclusion, the AMA, CMA, and SCCM struggled with many of the profound and troubling issues that the court below addressed and that are inherent in the questions presented by the petition. *Amici* respectfully submit that this case, like the parallel case pending on petition for writ of certiorari to the United States Court of Appeals for the Second Circuit (see note 2, *infra*), raises issues of vital importance to physicians and, more broadly, to the nation. Accordingly, *amici* urge the Court to grant the petition.

BACKGROUND—PHYSICIAN-ASSISTED SUICIDE

1. Physician-assisted suicide occurs "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics*: *Current Opinions* § 2.211 ("*Code of Medical Ethics*") (App. 1a); see also AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues in L. & Med. 91, 92 (1994) (App. 3a-4a). What makes physician-assisted suicide distinct from treatments that may result in loss of life is that the physician provides medical assistance *for the purpose* of killing the patient. As such, it is an action fundamentally different from two other types of physician action involving the loss of life.

The first is the provision of palliative treatment that may have the consequence of hastening death, but that is provided to the patient for the purpose of easing the patient's pain. The second is the withholding or withdrawal of life-sustaining treatment at the request of the patient or appropriate surrogate. In each of these two cases, although death is the consequence of the physician's action, the purpose of the action is not to cause death. In the case of palliative care, the purpose of the physician's action is to ease the patient's physical pain. In the case of withdrawal of treatment, the purpose is to respect the patient's wishes that the patient's underlying disease be allowed to take its course without further medical intervention. In neither case does the physician employ the instruments of medicine for the purpose of ending the patient's life. The distinctions between these cases preserve both the physician's role as healer and the patient's right to self-determination. Their recognition is crucial to the definition of the ethical practice of medicine.

2. The ethical injunction against physician-assisted suicide has origins at least as ancient as the Hippocratic Oath, which states that "physicians shall give no deadly drug to any, though it be asked of [them], nor will they counsel such." The profession's modern prohibition is, however, no mere vestige of history. As the AMA's Council on Ethical and Judicial Affairs has stated,

physician-assisted suicide is "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Code of Medical Ethics* § 2.211 (App. 1a). For example, as healer, the physician's role is to provide the patient with appropriate medical treatment when the patient desires it and to relieve pain and provide care designed to comfort the patient, even if further medical treatment is unwanted by the patient. The physician's commitment to support the patient creates a foundation for patient trust that the physician will do whatever possible, consistent with the patient's informed wishes, to promote the patient's health and well-being and to ease the patient's pain.

Permitting a physician to certify a patient as belonging to a death-eligible class, and then to assist that patient in taking his or her life, is incompatible with the physician's healing role. The willingness of many patients to seek medical care is founded on their trust that physicians are committed to preserving life and health. The knowledge that some physicians would willingly assist patients in killing themselves would undermine that trust and would, for example, likely deter or delay some individuals from seeking medical care. Physician-assisted suicide thus ultimately undermines the trust that is essential to the physician-patient relationship.

The consequences to the physician-patient relationship and to the public health of destroying that trust should not be underestimated. As two accomplished bioethicists have concluded,

> 'The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumental and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.'

Decisions Near the End of Life, 267 J.A.M.A. 2229, 2232 (quoting T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* (3d ed. 1989)).[1]

By way of example, the legalization of assisted suicide could intensify the pressure on gravely ill patients to choose to die in order to relieve their families and friends of the financial and emotional burdens of their illnesses. Recent studies indicate that it is these concerns—rather than intractable pain—that most often motivate patients' requests for physician-assisted suicide. See *"Physician-Assisted Suicide in the United States": Hearing Before the Subcomm. on the Const. of the House Comm. on the Judiciary*, 104th Cong., 2d Sess. (1996) (written testimony of Lonnie Bristow, M.D., President of the American Medical Association); see also Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 Issues in L. & Med. 415, 426-27 (1995). These pressures may be keenly felt by the least-privileged members of our society. As John Pickering, the Chair of the ABA Commission on Legal Problems, noted recently,

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[1] Another noted ethicist recently expressed the same concerns in starker terms:

> Do we really want our doctors to be licensed agents of death? Should they be permitted or encouraged to prescribe (and, later, to inject) poison? Shall the mantle of privacy that protects the doctor-patient relationship, in the service of life, now also cloak decisions for death? Do you want your doctor deciding, on the basis of his own private views, when you still deserve to live and when you now deserve to die, when you should be offered death as a "therapeutic option"? And what about the doctor you would never go to: do you want him also licensed to kill? In short, shall the healing profession become also the death-dealing profession?

"Physician Assisted Suicide in the United States": Hearing Before the Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess. (1996) (written testimony of Leon R. Kass, M.D., Addie Clark Harding Professor, University of Chicago, pp. 2-3).

> [b]efore there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burdens of health care can hardly permit voluntary choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.

Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. R. 735, 738-39 & n.17 (1995) (quoting John H. Pickering, *The Continuing Debate Over Active Euthanasia*, Bioethics Bulletin (ABA) 1, 2 (Summer 1994)). The interpersonal and subjective nature of these pressures, moreover, makes them particularly difficult to address through state regulation.

Medical studies further call into question the voluntariness of many requests for assisted suicide. Contrary to the suggestion of the court of appeals, Pet. App. A-74, the desire to hasten death is not a necessary concomitant of serious illness. A physician and leading author on suicide reports that "many patients and physicians displace anxieties about death onto the circumstances of dying"; by assisting dying patients not in suicide but in directly confronting the fear of death, the physician "may focus a patient on what he can achieve in whatever life can still offer." Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 Issues in L. & Med. 123, 128 (1994). Notably, one study of hospice patients found that the majority "did not want to die; and all those who desired death were suffering from major depression." Osgood, *supra*, at 427; see also Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 New Eng. J. Med. 1100, 1101 (1991); James H. Brown *et al.*, *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psychiatry 208 (1986). Because most physicians have not received extensive psychiatric training, Osgood, *supra*, at 430, there is a significant possibility that they will fail to diagnose treatable mental illness and, consequently,

will assist patients to commit suicide even though their psychological condition could be treated.

The option to assist a patient's suicide also will likely divert the attention of some physicians from providing therapeutic counseling, care, and comfort to their patients. Peter A. Singer & Mark Siegler, *Euthanasia—A Critique*, 322 New Eng. J. Med. 1881, 1883 (1990). If assisting suicide were legitimated, some physicians might be reluctant "to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death." *Decisions Near the End of Life*, *supra*, at 2232. Assisted suicide also could become for physicians an inappropriate "way of dealing with the frustration of being unable to cure the disease." Herbert Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 128. "[B]y making death a medical decision," assisted suicide gives the physician "the illusion of mastery over the disease and the accompanying feelings of helplessness." *Id.* Moreover, in view of the escalating pressures on health care professionals to reduce the costs of treatment, see generally Ezekiel Emanuel, *Cost Savings at the End of Life*, 275 J.A.M.A. 1907 (1996), lifting the prohibition of physician-assisted suicide could reduce the countervailing pressure that would otherwise exist to improve the ability to treat patients with acute pain and depression.

Finally, the needs of the vast majority of patients with serious illnesses can be addressed in ways more compatible with the physician's role as healer. As the AMA's Council on Ethical and Judicial Affairs stated in 1994,

> Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Code of Medical Ethics § 2.211 (App. 1a). A number of studies point out that physicians often fail adequately to manage their patients' pain, Osgood, *supra*, at 428 & nn.36-39, and that most patients who seek to hasten death change their minds when their pain is successfully controlled, *id.* at 429. Indeed, experts in the field of pain control have shown that "almost all terminally ill patients can experience adequate relief with currently available treatments." Judith Ahronheim & Doron Weber, *Final Passages: Positive Choices for the Dying and Their Loved Ones* 102 (1992); see also Robert D. Truog, *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992); *Physician-Assisted Suicide*, *supra*, at 94 (App. at 6a). Through aggressive treatment of pain, which physicians ethically may and should provide even if the medication were to hasten the patient's death, physicians can ease the pain that prompts certain patients to consider suicide. The increasing availability of hospice care and techniques of patient-controlled analgesia, moreover, will likely help significantly to restore patients' sense of autonomy.

REASONS FOR GRANTING THE PETITION

The Ninth Circuit's lengthy decision below is a sweeping and unprecedented constitutional ruling. It is controlling authority for the laws of nine states and, if widely followed, would partially invalidate the laws of most states. See Pet. App. at A-135 to A-136 nn.10-12. Yet the decision lacks solid grounding in the decisions of this Court and conflicts at numerous points with decisions of other courts of appeals and state supreme courts.

Furthermore, the decision rejects as insubstantial one of the core, long-established, and defining principles of ethical medical practice. The opinion's broad language and mischaracterization of existing medical practice has already caused significant confusion and concern within the medical community. If left to stand by this Court, the decision will seriously compromise the ethical practice of

medicine and cause irreparable harm to patients. The Court should therefore grant the petition in this case.[2]

I. THE COURT OF APPEALS' FINDING THAT TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONALLY PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE MERITS THIS COURT'S REVIEW

The Ninth Circuit, sitting *en banc*, invalidated a Washington statute that makes it a felony to "aid[]" another's suicide to the extent the statute applies to physicians who prescribe lethal drugs to patients for the purpose of enabling them to commit suicide. Under the Due Process Clause of the Fourteenth Amendment, the court held that the statute unreasonably interfered with what the court identified as a fundamental liberty interest of terminally ill patients in "the choice of how and when one dies," and, in particular, "in hastening what might otherwise be a protracted, undignified, and extremely painful death." Pet. App. A-9 to A-11, A-113, A-114, A-116. In so holding, the Ninth Circuit misconstrued this Court's decisions in *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), and reached a result on this issue that conflicts with the analysis of the Second Circuit, see *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), *pet. for cert. pending*, No. 95-1858 (filed May 16, 1996), and with the holding of the Michigan Supreme Court in *People* v. *Kevorkian*, 527 N.W.2d 714 (Mich. 1994),

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[2] For the same reasons, the Court also should grant the petition of the State of New York to review the decision in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), *pet. for cert. pending*, No. 95-1858 (filed May 16, 1996). The Second Circuit, although disagreeing with the Ninth Circuit about the existence of a liberty interest in physician-assisted suicide under the Due Process Clause, employs reasoning similar to the Ninth Circuit's analysis of the state's interests to invalidate a comparable New York statute under the Equal Protection Clause of the Fourteenth Amendment.

cert. denied sub nom. Hobbins v. *Kelley*, 115 S. Ct. 1795 (1995), that no such liberty interest exists.

Neither *Cruzan* nor *Casey* provides a basis for finding a constitutional liberty interest in obtaining a physician's assistance to commit suicide. The liberty interest discussed in *Cruzan* is grounded in the common law protection afforded to every person to refuse unwanted medical treatment. 497 U.S. at 269-70. Medical treatment performed without the patient's consent historically has been treated as a battery—a physical invasion of bodily integrity—excusable only in emergency circumstances. *Id.*; see W. Page Keeton, *Prosser & Keeton on the Law of Torts* 39-42, 190 (5th ed. 1984). The right to refuse treatment is the "logical corollary" of this longstanding common law prohibition against medical treatment without the patient's informed consent. *Cruzan*, 497 U.S. at 270.

Physician-assisted suicide has no comparable common law foundation. It has no antecedent, for example, in the common law right to avoid a physical invasion of bodily integrity. Assisted suicide, moreover, has been unlawful in most states for decades, further undermining the view that it is a legitimate form of medical treatment. See Pet. App. A-135 to A-136 & nn.10-13. Given the courts' historic reluctance to recognize a right to obtain medical treatment, see, *e.g.*, *New York State Ophthalmological Soc'y* v. *Bowen*, 854 F.2d 1379, 1389-92 (D.C. Cir. 1988), *cert. denied*, 490 U.S. 1098 (1989), it would be extraordinary if the first medical treatment to be recognized as a constitutional entitlement were a course of drugs intended to kill the patient. The logic of *Cruzan*, therefore, lends no support to the lower court's judgment here.

The Ninth Circuit's reliance on *Casey* also is misplaced. Although *Casey* contains language that, taken out of context, would support not only the liberty interest claimed here but an almost infinite array of interests, see generally Pet. App. A-56 to A-58 (quoting *Casey*, 505 U.S. at 851-53), it is unlikely that the Court intended to bind itself to such a sweeping expansion of the scope of personal liberty. This is particularly true given that the Court elsewhere noted that the liberty interest at issue in *Casey* was "unique," 505 U.S. at 852, and that the Court's judgment only narrowly reaffirmed, chiefly on grounds of *stare decisis*, a previously recognized liberty interest, *id.* at 854-71.

Nor is there any sound basis, factually or legally, for defining a fundamental liberty interest possessed only by those who are "terminally ill." As an initial matter, this class of individuals cannot accurately be defined. The Ninth Circuit's *en banc* decision leaves the definition of this class to the states. Pet. App. A-98 to A-99. As the Ninth Circuit three-judge panel noted, however, "[t]here is wide disagreement in definition of terminally ill among the states." Pet. App. D-18.[3] Moreover, because uncertainty remains an ineluctable aspect of medicine, it is all too often impossible as a practical matter to determine when a person meets any given criteria for terminal illness. And even if, contrary to experience, physicians could meaningfully and reliably identify a class of "terminally ill" patients (however defined), the Ninth Circuit offers no principled constitutional basis for granting only to individuals in that class the right to a physician-assisted suicide. The Ninth Circuit's reliance on the abortion cases, for example, would certainly support the right of any competent individual to obtain a physician-assisted suicide.

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[3] The varying criteria that states employ are vague and unenforceable. For example, Washington law states,

> "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

Wash. Rev. Code § 70.122.020(9).

It is therefore not surprising that the Second Circuit in *Quill* and the Michigan Supreme Court in *Kevorkian* expressly disagreed with the proposition that "either *Cruzan* or *Casey* preordains that the Supreme Court would find that any persons, including the terminally ill, have a liberty interest in suicide that is protected by the Fourteenth Amendment." *People* v. *Kevorkian*, 527 N.W.2d at 728; see *Quill* v. *Vacco*, 80 F.3d at 725 (declining "to identify a new fundamental right, in the absence of direction from the [United States Supreme] Court."); *id.* at 737 (Calabresi, J., concurring) ("[N]either Cruzan, nor Casey, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws [prohibiting physician-assisted suicide] invalid"). The conflict on this point alone merits this Court's review. See Pet. at 20-22.

II. THE COURT OF APPEALS' HOLDING THAT STATES LACK A JUSTIFIABLE INTEREST IN PROHIBITING PHYSICIAN-ASSISTED SUICIDE ALSO MERITS REVIEW

The decision below also merits review insofar as it dismisses the interests relied upon by the State of Washington in support of its prohibition against physician-assisted suicide. The interests and policy concerns that support a continued ban on physician-assisted suicide are numerous and compelling. The Ninth Circuit's result-driven analysis improperly casts them aside in favor of the court's own policy analysis. *Amici* would particularly draw the Court's attention to the tone of the opinion, by turns hostile, sarcastic, and disparaging, as the court rejects the views submitted by the AMA below.[4]

[4] *See, e.g.*, Pet. App. A-80 to A-81 n.95 (chiding the AMA for "sugarcoat[ing]" the facts; suggesting that the AMA's ethical opinions contain "euphemistic" language to "salve the conscience of the AMA" at the expense of the "realities of the practice of medicine"); *id.* at A-95 (deriding "tradition-bound AMA members" for citing to the Hippocratic Oath in view of some of its "preposterous" positions).

Two aspects of the lower court's ruling deserve particular attention. First, central to the Ninth Circuit's analysis (and the linchpin of the Second Circuit's equal protection holding in *Quill*) is the view that there is no meaningful distinction between physician-assisted suicide on one hand and withdrawal of life-prolonging treatment, or the provision of life-shortening analgesia, on the other. Second, the Ninth Circuit expressed confidence that the state and medical profession could protect the public from any adverse consequences that might otherwise ensue from the legalization of physician-assisted suicide. Both conclusions are unwarranted.

1. The Ninth Circuit could "see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life" because "the death of the patient is the intended result as surely in one case as in the other." Pet. App. A-82.[5] Surely the law can be informed by more careful reasoning. It is true that, in each case, death is the result. But it is only the latter act, involving the prescription of a lethal drug, of which it can fairly be said that both the doctor and patient intend to use medical means to cause the death of the patient. By contrast, in the withdrawal of treatment, the patient intends to let the underlying illness take its course *without* further medical intervention. Out of respect for the patient's long-recognized right to be free of unwanted medical intervention, the physician must acquiesce in the patient's judgment. Examples of such judgments include that of the Jehovah's Witness to refuse a necessary blood transfusion, or of a Christian Scientist to refuse life-saving surgery. "To call these judgments [to refuse or withdraw treatment], and the ensuing omission of treatment, 'intending' death distorts what actually hap-

[5] The rejection of these distinctions also formed the basis for the Second Circuit's finding that New York's prohibition of physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment. *See Quill*, 80 F.3d at 727-29.

pens. . . . [I]f I stop shovelling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby intending a driveway full of snow?" Kamisar, *supra*, at 755 & n.90 (quoting Daniel Callahan, *The Troubled Dream of Life* 77-78 (1993)); see, *e.g.*, *McKay* v. *Bergstedt*, 801 P.2d 617, 626 (Nev. 1990) (noting difference between "choosing a natural death summoned by an uninvited illness or calamity and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying"); Pet. App. C-10 n.12 (noting numerous judicial decisions that distinguish withdrawal of treatment from suicide).

The importance of the distinction, and the Ninth Circuit's analytic failure, can be seen in the court's discussion of Nancy Cruzan. In the Ninth Circuit's view, Nancy Cruzan "did not die of an underlying disease" but rather "was allowed to starve to death." Pet. App. A-79 & n.91. From this, the court reasoned more broadly that, when a doctor authorizes withdrawal of life-sustaining treatment, he "intends that, as a result of his action, the patient will die an earlier death than he otherwise would." *Id.*

The court simply missed the crucial point about Nancy Cruzan's case. Our society does not, and never has, forced people to accept medical treatment that would prolong their lives merely because the treatment is available. That principle has taken on added importance as life-prolonging medical technology has become more sophisticated and potentially intrusive. Until recently, an accident victim like Nancy Cruzan, who was comatose and could no longer take food or fluids by mouth, would have died from injuries sustained in that accident. Advances in medical treatment, such as tube feeding, now permit persons so afflicted to survive. But the fact that such treatment is available to those who want it does not mean that, when a person refuses such treatment, the person's death is not caused by the underlying disease or injury. Nancy Cruzan's feeding tube was administered to give her a chance to survive and recover consciousness. When,

after eight years, it became clear that she would never recover, the physicians who removed her feeding tube did so out of respect for her right to stop receiving such assistance.

For similar reasons, the Ninth Circuit also erred in failing to recognize that the administration of aggressive pain control, even when it may have the consequence of hastening death, also differs ethically from physician-assisted suicide. Typically, the provision of medication in doses strong enough to relieve pain will not bring about a patient's death. See Truog, *supra*, at 1680-81. But even in a case where palliative treatment might be said to hasten death or increase the risk of death, where the intention behind the treatment is to alleviate pain, the provision of such treatment is ethical and fully consistent with a physician's role as healer.

Here, too, the Ninth Circuit confused the issue of intent, asserting cavalierly that "doctors are generally permitted to administer death-inducing medication, as long as they can point to a concomitant pain-relieving purpose." Pet. App. A-77. This is incorrect. Where a physician prescribes treatment for the purpose of causing death, the physician has exceeded the bounds of ethical medical practice regardless of what other purpose the physician may "point to." Judge Kleinfeld understood the crucial ethical distinction, and expressed it well by analogy: In deciding to order American soldiers onto the beaches of Normandy, General Eisenhower knew full well "he was sending many American soldiers to certain death," yet he intended by this order not to kill the soldiers but to "liberate the beaches, liberate France, and liberate Europe from the Nazis." Pet. App. A-163 (Kleinfeld, J., dissenting).

2. The Ninth Circuit also underestimated the danger of adverse consequences likely to flow from its decision and overstated the state's ability to cope with them through methods short of prohibiting assisted suicide.

First, by blurring the distinction between aggressive pain management on the one hand and euthanasia on the other, the Ninth Circuit decision may lead many physicians who believe assisting in suicide to be unethical to be unduly cautious in managing their patients' pain. Ironically, because many terminally ill patients do not receive enough analgesia, such a reaction would only increase the number of patients that would seek, needlessly and tragically, to end their pain by ending their lives. In view of the need more aggressively to combat the acute pain suffered by some patients, it is imperative that states be permitted to confirm and reestablish this sound ethical distinction in our nation's laws.

Similarly, the court's ruling that there is no meaningful distinction between honoring a patient's request to withdraw treatment and writing a prescription for lethal drugs may increase some physicians' reluctance to honor patients' requests to withdraw treatment. Such a result would be particularly unfortunate given the years of effort devoted to increasing physicians' acceptance of the patient's right to refuse life-sustaining treatment, and the importance to the medical profession and to the public that such wishes be honored.

More fundamentally, the decision may well lead to significant numbers of cases in which lethal medications are administered to patients without their consent. In this regard, the Netherlands' experience is instructive. Although the Dutch law prohibiting physician-assisted suicide has not been repealed, the Netherlands has permitted its physicians to provide such assistance so long as certain express guidelines and safeguards developed by the medical profession are followed. In 1990, the Dutch Government appointed a committee, chaired by the Attorney General of the Supreme Court, Prof. J. Remmelink, to investigate the administration of euthanasia-related medical practices in the Netherlands. After conducting three large-scale studies, each involving hundreds of physicians, the Remmelink Commission reported that over

1,000 cases of active involuntary euthanasia—that is, the administration of fatal drugs with the intent to kill, performed without the knowledge or consent of the patient—took place in the Netherlands each year, even though medical guidelines specifically prohibited the practice.[6] The Netherlands' experience calls seriously into question the possibility of limiting abuse through mere regulation of physician-assisted suicide.

Moreover, the Ninth Circuit's decision, if upheld, is likely to increase significantly the number of suicides of persons with treatable mental depression and physical pain or who are not terminally ill. Studies report that a number of Dutch physicians assisted in the suicides of patients who were neither physically ill nor suffering from untreatable pain.[7] Of course, one need not look abroad for examples. Cases of physician-assisted suicide carried out under similar circumstances have also been reported in the United States.[8]

The above examples alone should be sufficient to justify a state's decision to prohibit assisted suicide. That evidence confirms that a state at a minimum could rationally decide that physician-assisted suicide provides far more potential for abuse than does withdrawal of un-

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[6] *See* Richard Fenigsen, Comment, *The Report of the Dutch Governmental Committee on Euthanasia*, 7 Issues in L. & Med. 339, 340-42 (1991).

[7] *E.g.*, Herbert Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 123, 129 (discussing assisted suicide of "physically healthy fifty year old [Dutch] woman who had lost her two sons and who had been recently divorced from her husband").

[8] *See, e.g.*, Richard Leiby, *Just How Sick Was Rebecca Badger?*, Washington Post A-1 (July 29, 1996) (reporting county medical examiner's conclusion that autopsy of woman who committed suicide with Dr. Kevorkian's assistance showed no "evidence of medical disease"); Kamisar, *supra*, at 740 (observing that Dr. Kevorkian's first suicide "patient", Janet Adkins, "might easily have lived for many more years" since she was in only initial stages of Alzheimer's disease).

wanted life-prolonging medical treatment. It suggests that physician-assisted suicide cannot and will not, in practice, be limited only to competent patients whose death is imminent and whose request for a prescription for life-ending medication can confidently be described as voluntary. Rather, it strongly suggests that—regardless of the safeguards imposed—assisted suicide may become routine, may involve many patients who are not ill and who are not (or need not be) wracked with pain, may be prompted by displaced anxiety over the fear of death that psychiatric treatment could address, and may result from the decisions of physicians or families rather than patients that such treatment is in the patient's interest.

Although the Ninth Circuit professed concern about "abuse," Pet. App. A-102, the court's purported solution to these profound problems is ironic and unsatisfactory. After riding roughshod for pages over the medical profession's adherence to longstanding ethical principles, the Ninth Circuit blandly asserted "that sufficient protections can and will be developed by the various states with the assistance of the medical profession . . . to ensure that the possibility of error will be remote." Pet. App. A-103 to A-104. Experience to date suggests, however, that such safeguards are not likely to be effective. Moreover, the very fact that the court thought them necessary calls into question its rejection of the seriousness of the state's interest in an outright prohibition.

Even more fundamentally, the lower court's willingness to cast aside a longstanding ethical norm itself seriously undermines the likelihood that professional standards will operate to keep the exercise of the court's newly announced liberty interest from spinning out of control. For example, in one of the Ninth Circuit's most misguided passages, the court suggests that patients would be better off if physicians were given "a choice" as to which ethical standards they will adhere to, thereby enabling patients to seek out physicians who offered the

services they wanted. Pet. App. A-96 & n.112. This view is incompatible with the existence of meaningful ethical standards which, if they are to serve the policing role that the Ninth Circuit envisions in the future, must be applicable to all within the profession.

At bottom, the Ninth Circuit's cynical approach to medical ethics threatens the integrity of medical practice. "No human being can escape the reality of being sick and being cared for. All must seriously contemplate what a divided profession without a common set of moral commitments would mean." Edmund D. Pellegrino, *Rethinking the Hippocratic Oath*, 275 J.A.M.A. 1807, 1809 (1996). Ultimately, uncertainty regarding the vitality of even some physicians' central ethical commitment to preserve the life and health of patients can serve only to undermine the public's trust and confidence in physicians and in the medical profession.

* * * * *

Physician-assisted suicide, appropriately defined, is contrary to basic tenets of the medical profession and to the laws of most states. The Ninth Circuit's faulty case analysis and poorly reasoned assessment of the states' interests strongly suggest that it erred in concluding that patients have a constitutional right to such assistance. But regardless of the merits, the question is of such exceptional national importance that, if the longstanding prohibition, both ethical and legal, on assisted suicide is now to be declared unconstitutional, such a declaration should come only from this Court after plenary consideration of this issue.

CONCLUSION

For the reasons stated above and in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

American Medical Association Opinion 2.211: Physician-Assisted Suicide

Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (*JAMA*. 1992; 267: 2229-2233)

APPENDIX B

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION

Subject: Physician-Assisted Suicide (Resolution 3, A-93)

Presented by: John Glasson, M.D., Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Louis R. Zako, M.D., Chair)

Introduction*

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report, "Decisions Near the End of Life." In that report, the Council concluded that physician-assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not . . . participate in assisted suicide." Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most

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* In accordance with the Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws (I-91), this report may be adopted, not adopted, or referred. It may only be amended, with the concurrence of the Council, to clarify its meaning.

fundamental measures of human value and worth." Similarly, in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.' "

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins. The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull. Other public events quickly followed. Physician-assisted suicide, together with euthanasia, was placed on the public ballot in Washington state, in November 1991, and in California, in November 1992. Both times, voters turned down proposals to legalize physician-assisted dying. In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide. In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician-assisted suicide.

Definitions

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia the physician administers the death-causing drug or other agent.

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering,

not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.

Ethical Considerations

Inappropriate Extension of the Right to Refuse Treatment

In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible. The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-

assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.

The Physician's Role

The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity, and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain. Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled. Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain. The patient's treatment

plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decisionmaker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.

Relieving the patient's phychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal phychological and spiritual

support of family and friends." Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members, and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention. Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/or antidepressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued. Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family, and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected, and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation, and other comfort care for the associated discomfort.

"Slippery Slope" Concerns

Permitting assisted suicides opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician-assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands, however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision-maker, since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

Recommendations

In lieu of Resolution 3, A-93, the Council on Ethical and Judicial Affairs recommends that the following statements be adopted and the remainder of this report be filed:

1. Physician-assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
4. Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling, and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

[A complete list of references can be obtained from the Office of General Counsel.]

APPENDIX C

AMERICAN MEDICAL ASSOCIATION

Opinion 2:20 Withholding or Withdrawing Life-Prolonging Medical Treatment (formerly Opinion 2.18)

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The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. If the patient is incompetent to act in his own behalf and did not previously indicate his preferences, the family or other surrogate decisionmaker, in concert with the physician, must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the surrogate decisionmaker and physician should consider several factors, including: the possibility for extending life under humane and comfortable conditions; the patient's values about life and the way it should be lived; and the patient's attitudes toward sickness, suffering, medical procedures, and death.

Even if death is not imminent but a patient is beyond doubt permanently unconscious, and there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or permanently unconscious patient, the dignity of the patient should be maintained at all times. (I,III,IV,V)